**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

SOUTH TEXAS COST CONTAINMENT
102 E. MAIN
ALICE, TX 78332

**Respondent Name**

ACE AMERICAN INSURANCE CO

**Carrier's Austin Representative Box**

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**MFDR Tracking Number**

M4-10-4552-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** The requestor did not submit a position summary.

**Amount in Dispute:** $567.41

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Charges billed from Dr Charles Craig were disputed Based on Late Filing of Bill per the Texas AMA Guide.

**Response Submitted by:** ESIS, P.O. Box 31108, Tampa, FL 33631

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| 10/27/2009 | 99204-25, 99080-73, G0281-GP, 97110-25 | $567.41 | $565.67 |
| 10/28/2009 | 99212-25, 72110-WP, G0281-GP, 97110-25 | | |
| 10/30/2009 | 99214-25, G0281-GP, 97110-25 | | |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. 28 Texas Administrative Code §129.5 sets out the procedures and reimbursement for Work Status Reports.
5. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of Workers' Compensation

Professional Services provided on or after March 1, 2008.

6. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
7. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 04/20/2010
   - 29-The time limit for filing has expired.
   - 855-066- Based on Fee schedule guidelines, bills submitted after the 95th day after the date of service are disallowed. $0.00

**Issues**

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

**Findings**

1. Pursuant to 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that Texas Labor Code §408.0272 applies to the service in dispute. For that reason, the requestor in this dispute was required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus 5 days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. Review of the documentation submitted by the requestor finds a copy of a U.S. Postal Service Certified Mail Receipt which supports that a bill was submitted to the respondent on 11/12/2009.
3. In accordance with Texas Labor Code §408.027, the Requestor has timely submitted bill to the respondent. Therefore, reimbursement is recommended per 28 Texas Administrative Code §134.203 as follows:

   CPT Code 99204-25: 53.68 WC CF/36.066 Medicare CF x 135.43 Participating amount = $201.57. The requestor is seeking $163.25. This amount is recommended.

   CPT Code 99080-73: $15.00 is recommended per 28 Texas Administrative Code §129.5(i).

   CPT Code G0281-GP: 53.68 WC CF/36.066 Medicare CF x 11.00 Participating amount = $16.37 x 3 DOS= $49.11. The requestor is seeking $48.03 (16.01 x 3 DOS). This amount is recommended

   CPT Code 97110-25: 53.68 WC CF/36.066 Medicare CF x 26.83 Participating amount = $39.93 x 3 DOS = $119.79. The requestor is seeking $117.63 (39.21 x 3 DOS). This amount is recommended.

   CPT Code 99212-25: 53.68 WC CF/36.066 Medicare CF x 34.82 Participating amount = $51.82

   CPT Code 72110-WP: 53.68 WC CF/36.066 Medicare CF x 48.74 Participating amount = $72.54

   CPT Code 99214-25: 53.68 WC CF/36.066 Medicare CF x 87.69 Participating amount = $130.51. The requestor is seeking $97.40. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $565.67.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $565.67 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | 04/19/2012 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.